STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 123285-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _6th____ day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On September 9, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on September 16, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the BCBSM *Group Conversion Comprehensive Health Benefit Certificate* (the certificate) and two related riders governing copayment requirements and preventive health care services.

On May 26 and 27, 2011, the Petitioner received diagnostic radiology services from XXXXX, Inc. BCBSM approved $1,392.20 for this care and, after applying a 30% copayment of $417.67, paid $974.53.

The Petitioner appealed BCBSM's application of the 30% copayment. BCBSM held a managerial-level conference and then issued a final adverse determination dated September 6, 2011, affirming its position.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's diagnostic tests?

IV. ANALYSIS

BCBSM's Argument

In the final adverse determination sent to the Petitioner, BCBSM's analyst wrote:

> As you may know, you are covered under the *Group Conversion Comprehensive Health Care benefit Certificate.* Page 3.10 of the *Certificate* explains that we pay for physician services to diagnose disease, illness, pregnancy or injury through diagnostic radiology services. However, the *Certificate* is amended by Rider GC-LCP. The Rider explains that a 30 percent copayment is required on all covered services up to a maximum of $1,000.00 per contract, per calendar year.
>
> Additionally, Rider HCR-IB-PCB3 also amends your *Certificate*. This Rider explains that we pay 100 percent of our approved amount for immunizations and preventive care benefits that are mandated by the Patient Protection and Affordable Care Act (PPACA) at the time the services are performed. Based on the reported diagnosis, the services in question were not routine in nature. Therefore, the cost share [was] applied correctly.
>
> To give your appeal full consideration, I reviewed our telephone call logs, and confirmed there were not any inaccuracies in the benefit information provided. As such, I cannot approve payment and you remain responsible for the balance ($417.67).

Petitioner's Argument

The Petitioner states that in May 2011 he was experiencing chest pains so he went to his local doctor who did an EKG and a chest x-ray. The doctor then ordered a stress test and echocardiogram to be performed a week later. Before having the tests, the Petitioner states he called BCBSM and talked to a customer service representative to determine if these tests would be covered without additional cost to him. He states the representative indicated that he was covered 100%. The Petitioner went ahead with the tests based on the conversation with BCBSM.

BCBSM provided coverage applying a 30% copayment for the services that totaled $417.67. The Petitioner states that normally he does pay a copayment although there have been medical services in the past that are covered at 100%. The Petitioner indicates that he probably would not have had the additional tests if he had not been assured that they were covered at 100%.

Commissioner's Review

The certificate amended by Rider GC-LCP requires a 30% copayment. Rider HCR-IB-PCB3 provides that there are no copayments for immunizations and preventive care services. However, in this case the Petitioner's medical tests were not preventive in nature; they were performed as part of the diagnosis and treatment of an existing medical problem. For that reason, the copayment is not prohibited and tests are subject to the normal 30% copayment required in Rider GC-LCP.

The Petitioner argues that his copayment requirement should be waived because he was given wrong information about his benefits and acted in reliance on that information. BCBSM denies this allegation. Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner is authorized to determine whether an insurer has correctly applied the terms of its insurance contract and state law. Because PRIRA has no hearing process, the Commissioner has no way to resolve factual disputes such as the one raised here which involves what was said in a telephone conversation.

The Commissioner finds that BCBSM's application of the 30% copayment was appropriate under the terms of the Petitioner's certificate and related riders.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of September 6, 2011, is upheld. BCBSM is not responsible for any additional reimbursement of the Petitioner's diagnostic services performed on May 26 and May 27, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner